MERIDIAN FIRE DEPARTMENT

Carbon Monoxide Report

(Please fill in and circle the following that applies)

DATE: _____ **Incident Number:_____**

Patient Name:_____

Age:_____ **Gender:_____** **If female, Pregnant: YES NO**

Smoker? YES NO If Yes, number of packs per day:_____

CO House Alarm? YES NO If Yes, Digitial Reading on home meter:_____

Confirmatory Reading by MFD? YE YES NO CO Level:_____ppm

Source of Exposure:_____

Location of patient in the building:_____

Symptoms List: (Check ALL that apply)

___Malaise, flu-like symptoms, fatigue
___Chest Pain, palpitations
___Confusion
___Hallucination(s)
___Nausea, vomiting, diarrhea
___Headache, drowsiness
___Visual disturbance, syncope, seizure
___Memory and gait disturbances
___Dyspnea on exertion
___Lethargy
___Depression
___Distractibility
___Agitation
___Abdominal Pain
___Dizziness, weakness, confusion
___Incontinence

1st Reading- Time:_____:_____ SpCO:_____% SpO2:_____%

2nd Reading- Time:_____:_____ SpCO:_____% SpO2:_____%
(After 5 minutes)

Any Difficulties?_____

Patient Transported? YES NO If yes, which facility? St Als St Lukes DT St Lukes Meridian